11-10-1997

DDASaccident053

Humanitarian Demining Accident and Incident Database
AID

DDAS Accident Report

Accident details

Report date: 19/04/2006

Accident number: 53

Accident time: 12:34

Accident Date: 10/11/1997

Where it occurred: Chianga Railway Bridge, Longonjo District, Huambo Province

Country: Angola

Primary cause: Field control inadequacy (?)

Secondary cause: Inadequate equipment (?)

Class: Vegetation removal accident

Date of main report: 14/11/1997

ID original source: GP

Name of source: INAROEE

Organisation: [Name removed]

Mine/device: PPM-2 AP blast

Ground condition: bridge and surrounds
hidden root mat
metal scrap
rocks/stones

Date record created: 23/01/2004

Date last modified: 23/01/2004

No of victims: 1

No of documents: 1

Map details

Longitude:

Latitude:

Alt. coord. system: Grid Square 1876

Coordinates fixed by:

Map east:

Map north:

Map scale:

Map series:

Map edition:

Map sheet: 255

Map name:

Accident Notes

inadequate equipment (?)

squatting/kneeling to excavate (?)

use of pick (?)

no independent investigation available (?)

handtool may have increased injury (?)

non injurious accident (?)

Accident report

The demining group were using a one-man drill at the time. In this, the deminer used the vegetation clearance and excavation tools as well as the detector. Every hour he had a ten minute rest break.

No independent accident report was made. The demining group carried out an internal accident report that was sent to the country MAC on14th November 1997 and was found on file there. The following summarises the content of that document.

The demining group started work at the site on 14th October 1997. The accident occurred in an area under a road bridge that passed over a railway line. Due to the "fragmented remains of a barbed wire fence" the deminers were working using an excavation technique that utilised a "probe and a short handled hoe". The deminer was also equipped with a hand trowel, a bucket for metal, garden shears, an end-of-lane stick, marking string and pegs, and a visor and a "blast protection jacket".

The victim began work at 07:00 and had worked with a ten minute break each hour until 12:34 when the accident occurred. The method involved excavating "to a depth of 20cm using a sideways sweeping motion" with the hoe [pick]. He had found one mine that morning and as he worked forward he encountered a rock ledge at only 5cm depth. He uncovered the rock for three metres until the ledge ended. At the edge of the rock was a tree root that the deminer tried to cut with the hoe. Either the movement of the tree root initiated the mine that was beside the edge of the rock or his hoe slipped and he initiated a PPM-2 with it. He was thrown backward two metres and his visor flew forward 1.5 metres. He landed on his back and had "no recollection of the blast". He stood up and started to collect his tools. He was "obviously confused". The paramedic led him to the medical post.

The report did not state it, but implied that the deminer's visor and blast jacket were damaged because they "are now held in the Huambo mines training room".

Conclusion

The investigators concluded that the victim was not using the hoe according to SOPs and was responsible for the accident. They commented that the supervisor should have supplied the deminer with "loppers", held in the central administration area.

Recommendations

The recommendations listed in the report were largely a record of "actions taken". For example, the victim had been moved to other duties until having passed a refresher course, the supervisor had been "forcefully reminded" that he should think about the deminers' needs and ensure they have the tools for the job, the Operations Officer had been "forcefully reminded" that it was his responsibility to ensure that the necessary tools were available and to brief the Programme Manager if they were not. It was also mentioned that the demining group was sourcing further loppers to ensure that there were enough for one between two men.

Victim Report

Victim number: 72 **Name: [Name removed]**

Age: **Gender:** Male

Status: deminer **Fit for work:** yes

Compensation: not made available

Time to hospital: not applicable

Protection issued: Short frontal vest
Long visor

Protection used: Short frontal vest,
Long visor

Summary of injuries:

COMMENT

No medical report was made available. The victim was shocked and confused but no injuries were recorded.

Analysis

The primary cause of this accident is listed as a *"Field control inadequacy"* because the deminer was working improperly and his errors went uncorrected.

The investigators report that the group was sourcing more loppers and this may be taken to imply that sufficient numbers of the tool were not available. If this was so, the failure to provide appropriate tools would be a serious management failing. The secondary cause is listed as *"Inadequate equipment".*

A "lopper" is usually a long handled tool for pruning the small branches of trees. The demining group's "lopper" was not seen. The use of a short-handled hoe or pick for excavation is fairly common. A similar tool was also used by this demining group in Mozambique and by all groups operating throughout Afghanistan.